by the questionnaire, allowing treatment before admission.

Surgical clinics fulfil three objectives: the diagnosis is considered, the patient's suitability for surgery and in particular anaesthesia is assessed, and diagnosis and treatment are discussed. Taking these points in reverse order, the implications of the diagnosis and treatment could easily be conveyed by letter, and the second objective could be covered by the questionnaire. I reviewed only patients admitted for operation and therefore did not address the first objective, but in most cases the diagnosis of hernia is obvious, and uncertain cases could still be assessed in outpatient clinics.

Collins points out that general practitioners are usually willing to follow up surgical cases, and it seems that the function of the preoperative outpatient appointment could often be undertaken by the patient's general practitioner. This would help to allow more complex consultations the 20 minutes that Collins recommends and prevent unnecessary waiting in busy clinics for patients with straightforward problems.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;**304**:1396. (30 May.)

International debt, death squads, and children

EDITOR,—Dorothy Logie's article on international debt casts a quite unjustifiable slur on Amnesty International in describing Amnesty as "distracting attention from the real exterminator of Brazilian children—namely, the burden of international debt."[1] This is a staggering misrepresentation of the facts. While it is incontestable that the root cause of the existence of street children is poverty and that poverty is inextricably linked to mortality, the brutality, torture, and murder in which the death squads indulge are extra horrors deliberately inflicted on the children. The horrifying photograph that accompanies the article, of a pile of bodies of children shot dead in Rio de Janeiro, is a clear illustration of the point.

Numbers of street children are unfortunately increasing in many Third World countries afflicted with international debt and other causes of poverty. Only in countries such as Brazil, Bolivia, and Guatemala are death squads made up of police and military personnel targeting the lives of such unfortunate young victims.

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1 Logie D. The great exterminator of children. *BMJ* 1992;**304**:1423-6. (30 May.)

AUTHOR'S REPLY,—The sentiments expressed in the opening paragraphs of my article are not mine but those of Dr Lauro Monteiro, a paediatrician who has dedicated many years to organising medical and legal help for thousands of street children in Rio de Janeiro. He fully acknowledges (as I do) Amnesty's excellent contribution in publicising the atrocities and murder of the children. The horrifying photograph of dead children is his. Two years ago, however, when Amnesty (along with other organisations) launched a worldwide campaign to focus attention on the killings, he considered that the international effort and outcry might have been more usefully focused on the injustice of international debt. As a Brazilian paediatrician, he sees debt killing many more children each year than either police or vigilantes but not attracting the same international outrage.

I am sorry that Amnesty has taken offence for it does excellent work. It is not an "either/or" situation: both debt and the murder of children need to be brought to the world's attention.

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"Gold standard" is an appropriate term

EDITOR,—P Finbarr Duggan draws attention to the fact that the term "gold standard" is being used more frequently in scientific work.[1] He sees this as a lamentable trend, but I take the opposite view. The gold standard is not the perfect test but merely the best available test.[2] The *Oxford English Dictionary* states that it is a "measure to which others conform or by which the accuracy of others is judged . . .; thing serving as a basis for comparison."

As science increases its hold on the practice of medicine we become more aware of the limitations of the clinical method. Unfortunately, we also become more aware of the limitations of various diagnostic tests. Nevertheless, at any given time there may well be a consensus that a given test in a given situation is the best available test. It therefore serves as the gold standard against which newer tests can be compared. When enough data have accumulated to make that gold standard untenable it can perfectly reasonably be replaced by another. This can then preside until it too is toppled.

Duggan states that because the subject is in a state of perpetual evolution gold standards are, by definition, almost never reached. On the contrary, it is absolute truth that is never reached; gold standards are constantly challenged and superseded when appropriate.

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1 Duggan PF. Time to abolish "gold standard." *BMJ* 1992;**304**:1568-9. (13 June.)
2 Versi E. Discriminant analysis of urethral pressure profilometry data for the diagnosis of genuine stress incontinence. *Br J Obstet Gynaecol* 1990;**97**:251-9.

Dispensing doctors

EDITOR,—John Warden is right that dispensing doctors have reason to feel nervous about the exchange in the House of Lords on 13 June, but they have no reason to be surprised by the health minister's comments, which have remained unchanged for many years.[1]

A comment made twice in the same debate by Baroness Cumberlege (parliamentary under secretary of state at the Department of Health), however, gives the whole profession much food for thought since it is unexplained. She drew attention to a "conflict of interest which potentially exists when one person both prescribes and dispenses."

Is she suggesting that general practitioners are potential thieves and fraudsters, or could it be that the department thinks that doctors prescribe to "line their own pockets" as the pharmacists would have the uninitiated believe? Does the Baroness Cumberlege think that dispensing doctors may prescribe inappropriately for their own profit?

These alternatives are insults to general practitioners. On close examination the Prescription Pricing Authority's annual reports for 1985-91 firmly disprove the second alternative.[2] Over those years dispensing doctors actually saved the government £33m (table); this amounts to an average of 23p per item dispensed. A secondary factor that gives the lie to the supposition is that there is a constant downward pressure on all prescribing (and therefore dispensing) by general practitioners and any such "pocket lining" would be quickly picked up.

The Dispensing Doctors' Association has asked Baroness Cumberlege for an explanation of her remark.

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1 Warden J. Dispensing with doctors? *BMJ* 1992;**304**:1530. (13 June.)
2 Prescription Pricing Authority. *Annual report*. London: PPA, 1985-91.

Medical abortion

EDITOR,—In the correspondence about the cost effectiveness of medical abortion both the cost of the drug and the facilities and staff required to deliver the service may have been overestimated.[1,2] The cost of the drugs in the United Kingdom—about £65—is based on the combination of 600 mg mifepristone (£44) and 1 mg gemeprost vaginal pessary (£21). Recent data have shown that the dose of mifepristone and gemeprost may be reduced without loss of efficacy.[3,4] Moreover, preliminary trials have suggested that oral misoprostol may be a cheaper (about £1), safer alternative prostaglandin.[5] If these studies are confirmed in larger trials it should be possible to reduce the cost of the drugs. The facilities and staff required to provide an effective, safe service for medical termination may also have been overestimated. On the basis of our experience in the past 10 years of nearly 1000 medical terminations in early pregnancy, we have established a protocol for a routine service entailing three outpatient visits.[6]

Mifepristone is given at the first visit after the initial outpatient consultation and counselling for termination. If the history and clinical examination confirm that the pregnancy is of less than nine weeks' gestation an ultrasound scan of the uterus is unnecessary. The second visit entails a stay of about four hours after the prostaglandin is given. We have shown that up to five women can be treated simultaneously in a sitting room with minimal nursing care. Only a minority (34%) preferred to lie down because they felt pain or nausea, or both. Most found the companionship of women in similar circumstances reassuring. Though a third follow up visit is not strictly essential for the 80% of women in whom the fetus

Annual cost of items dispensed by doctors and pharmacists, 1985-91

Year	Average cost per item less VAT (£)		Saving made by doctors per item (£)	Total saving by doctors (£m)	Potential saving had all doctors dispensed (£m)
	Doctors*	Chemists			
1985-6	4·629	4·877	0·248	5·227	82·909
1986-7	4·920	5·172	0·252	5·595	87·667
1987-8	5·288	5·552	0·264	6·256	102·544
1988-9	5·797	6·017	0·220	5·404	81·000
1989-90	6·098	6·321	0·223	5·792	85·261
1990-1	6·543	6·742	0·199	5·370	77·610
Total				33·644	516·991

*Pharmacists do not pay VAT so VAT has been deducted here to make the figures comparable.